PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Patients' experiences of the choice of GP practice pilot, 2012/13: a mixed methods evaluation
AUTHORS	Tan, Stefanie; Erens, Bob; Wright, Michael; Mays, Nicholas

VERSION 1 - REVIEW

REVIEWER	Rita Santos Centre for Health Economics, University of York
REVIEW RETURNED	18-Sep-2014

GENERAL COMMENTS	The paper is interesting but need to be revised to be more understood by all readers. A string statistical analysis at patient level would benefit the paper. The paper is interesting and focus in an actual problematic. However I suggest minor changes to text, to reported tables and if possible of further statistical analysis. The changes in the text and tables will increase the readability of the paper, while the statistical analysis would benefit the conclusions that the authors can make.

REVIEWER	Natasha Curry Nuffield Trust, UK
REVIEW RETURNED	22-Oct-2014

GENERAL COMMENTS	I thought this was a very clearly-written article on an interesting and highly relevant topic. You are clear about the limitations of the study yet it is a valuable contribution to the literature. I just has a few obsevations/questions: You excluded under 18s yet they are an important high-use group - did you consider surveying/interviewing their guardians? Minor question re numbers: on page 5 under 'pilot patient characteristics', numbers of patients are 1108 and 250 yet total numbers cited elsewhere are 886 and 188. I probably just overlooked where you explain this difference but maybe it should be made clearer? In the comparisons with existing literature, is there any more you could say about the use of walk in clinics? Do we understand how and which patients use them and how this is different to the patients

	in your study? I suspect that information isn't known but if there is any further comparison you can draw between patients using WICs and those using your sample practices, it would be very interesting.

VERSION 1 – AUTHOR RESPONSE

Response to reviewer 1:

The paper is interesting but need to be revised to be more understood by all readers.

A string [we assume the referee means ‘strong’] statistical analysis at patient level would benefit the paper.

the paper is interesting and focus in an actual problematic. However I suggest minor changes to text, to reported tables and if possible of further statistical analysis. The changes in the text and tables will increase the readability of the paper, while the statistical analysis would benefit the conclusions that the authors can make.

We have considered your comments and address each below. In response to your broader comments, we feel that we are unable to extend our statistical analysis due to the constraints of the pilot and thus of the evaluation itself. This was a 12-month pilot scheme in only 4 PCTs where the sample was comprised of patients who voluntarily registered, retained registration at, or presented to a participating practice. We were unable to know who patients were, or what practices they were registered with before joining the pilot. The evaluation was designed after the pilot was announced so we were not in a position to define the sample sizes either at practice or patient level.

In some cases, the meaning of your comments was not entirely clear (e.g. there appear to be missing words and/or unusual constructions in the comments), but we have tried to interpret them based on the context of the comment. We have highlighted some of these in italics in your comments.

Comments:

1. In the abstract the participants section should be explained more clearly,

This has now been clarified. This section now reads as: “analysis of routine data for 1108 out of area registered patients and 250 day patients”

in the results section the reported percentages should some [we assume the referee means ‘sum’] to 100% (not summing to 96.3%) and the conclusion section should avoid wording as " appeared".

This has now been clarified so the percentages sum to 100: “ A few could not be classified due to missing data (3.7%).”

We have removed the words ‘appeared to’ from the Abstract conclusions.

2. The first two bullet points of "strengths and limitations of the study" should be combined in a more obvious strength to the reader, since the first is a sum of the literature review and the second a results of the present study.

The first two bullet points under ‘strengths and limitations’ have been combined to make the ‘strength’ clearer to the reader. The revised text is as follows:

• A strength of this study is that it adds to the very slender evidence either from the NHS or other systems on the effects of widening patient choice of general practice, and specifically the effects of removing geographic boundaries. It reveals that patients reported high satisfaction with their experience in a short-term pilot of practice boundary removal and that most patients joined the pilot on grounds that the pilot practice was more convenient than their previous source of primary medical care.
3. Correct simple mistakes as ",(" in page 4 line 53 .

This has now been corrected.

4. In page 4, the second paragraph finishes with a phrase that confuses the reader, since the "other circumstances" appointed [meaning unclear] by the authors are actually the new scheme to improve GP choice by patients.

This has now been clarified to read “In other circumstances outside the pilot, practices have the discretion to allow any patient to register, but may choose not to offer services such as home visits to distant patients.“ In this case, “other circumstances” did not refer to the pilot but to the fact that practices have long exercised discretion and accepted patients from outside their practice areas on a case-by-case basis.

5. Sub-section Study design of Methods section should be more informative or not exist.

This has now been removed.

6. An explanations regarding which PCTs and practices the patients are attending should be given during the presentation of the data.

We have added more detail about the number of patients participating in the pilot in each PCT as follows:

“The vast majority of patients registered with, or attended, a pilot practice in Westminster, which accounted for 789/1108 (71%) of out of area registered patients and 196/250 (78%) of day patients, with the remaining 121/1108 (11%) and 52/250 (21%), respectively, in Nottingham, 114/1108 (10%) and 0/250 (0%), respectively, in Manchester, and 84/1108 (8%) and 2/250 (1%), respectively, in Salford.”

The numbers of patients at individual practices vary from 1 to 161 for out of area patients (average 26) and 1 to 116 for day patients (average, 6) so the sample sizes at practice and PCT level were too small to show significant differences. Eleven practices recorded no day or out of area registered patients. Details on patient participation rates by practice are available in the full evaluation report in reference 7 (see page 39).

7. The authors should be more clear about the number of patients, it's difficult to understand how many patients are day patients and out of area patients (only in page 7 the reader is inform about the total number of day care patients and out of area patients).

This has now been clarified in the abstract (as noted under comment 1) and methods section. The methods section now reads: “Basic quantitative profile data were collected for all 1358 (1108 out of area registered patients and 250 day patients) patients…”

Table 1 should also include numbers so the reader [can] understand what has been compared.

We have inserted a row for base numbers at the bottom of each table.

8. Following the previous point I suggest that the authors firstly explaining their sample and then report the differences in the data for day patients and out of area patients and the difficulty of accessing clinical data to out of area patients .

The sample included any patient that used the pilot. This paragraph has now been clarified:

“Routine data
Basic quantitative profile data were collected for all 1358 (1108 out of area registered patients and 250 day patients) patients who used the pilot between April 2012 and March 2013. For out of area patients, limited administrative information was available through the National Health Authority Information System (NHAIS, now Connecting for Health) on age, gender, new practice code and the first 3-4 digits of the patient’s home address post code. It was not feasible given the short duration of the pilot to negotiate permission to extract clinical data on out of area patients’ use of their new practices from practice computer systems. For day patients, clinical data were available on the number of visits, along with the reason and consequence of each since all day patient visits were separately recorded and transmitted to the PCT for payment purposes. The local area team removed all identifiable information from the day patient visit forms before sharing it with the research team.”

9. interviews: 18 out of area patients and 6 day patients

This has now been corrected.

10. postal survey - population that used the pilot GP practices (1358) : 188 out of area (replies from 64 - 34%) , 886 out of area patients (replies from 315 - 36%) and 284 pilot patients not included due to age (under 18) or address (not UK valid address).

This has been clarified to:

“We conducted a postal survey of all day (64/188, 34% response rate) and out of area registered (315/886, 36%) patients aged 18 years and over and with a permanent address in the UK. Out of 1358 pilot patients, 284 pilot patients were not included in the survey, of these, 260 were aged under 18…”

11. The authors describe the pilot practices in the following "In the four PCTs, 43 general practices out of 269 eligible practices volunteered for the pilot (with 20/53 (38%) of practices in Westminster, 7/63 (11%) in Nottingham, 8/102 (8%) in Manchester, and 8/51 (16%) in Salford)." It would be interesting to understand more about those practices, their patient list, QOF points and if they are Rural or Urban practices.

To address this point, we have inserted a reference to the full evaluation report and appendices, as this paper is limited to patient experiences. Chapter 3 of our publicly available report provides detailed analysis of practice characteristics, including list size, variations in QOF score, and how participating practices compare with non-pilot practices in the same PCT. Participating practices were all in urban areas. The amended texts are below:

“All participating practices were in urban areas”

“Pilot and non-pilot practices were similar in terms of list size, Quality and Outcome Framework (QOF) scores, and patient experiences and views in the GPPS (see the full report of the evaluation7, 8 for further details about practice characteristics, list size and QOF score).”

12. over 64% of patients have between 18 and 34 years and in box 1 the vignettes are for patients over 40. A vignette from a patient more similar to mean out of area patient would be more informative.

This has been amended. The first vignette in Box 1 is now a more representative patient.

“Male, age 28 years, in full-time employment, with chronic depression.
He has been registered with the same practice for 6 years He was invited to enter the pilot after revealing that he had moved out of the catchment area. He has a history of depression and felt he benefitted from staying at a practice where “they could see by my mood, my state of mind, that [an antidepressant] wasn’t working – in fact, having a stimulant anti-depressant as opposed to a sedative anti-depressant was probably causing me to be worse.” He wished to stay with this practice because he was satisfied with the service received, “it’s about the individual, rather than just being a number, rather than just being a bit of funding.””

13. In page 8, the authors report that they could [have] identified three types of day patients based in survey questions, but they don't report the answers to the second question "how the practice they had visited compared with their registered practice". The paragraph is also not clear since the authors give information of one interview between the report to survey questions.

The three types were developed based on responses to a number of the survey questions plus the free text responses relating to these questions. The qualitative interviews also informed the development of our day patient typology, especially Type 2, Temporary Resident, so we feel that this is a reasonable way to present the findings.

This paragraph has been changed to reflect this:

“The second type would have been more appropriately categorised as Temporary Residents or requiring ‘Immediate and Necessary’ care. Nearly one in five (18.8%) day patients fell into this type. This is consistent with qualitative interview findings that revealed some confusion among practices between the day patient option and existing provisions for urgent appointments in primary care.”

14. the subsection "Day patients' reasons for consulting a pilot practice" indices [meaning not clear] the reader in error, since the above paragraph stated that the main reason was convenience. The wording of the text should be revised so that each term (like reason) refer only to one definition .

This has now been retitled: Conditions for which day patients consulted a pilot practice

15. The percentages reported in the section "Day patients' reasons for consulting a pilot practice" don't sum to 100.

This has now been corrected. This section now reads as follows:

“A small proportion of patients preferred a specific practice or a specific doctor (e.g., if they had been registered at one practice before moving house and wanted to see their former GP while remaining registered with a local practice), received specialist care that their registered practice did not offer, or were not satisfied with the quality of care received at their registered practice (7.8%)”

16. If the authors have individual patient data from the surveys, they should try to model the responses of interest and use a difference in difference framework to reveal the difference between pilot and non-pilot patients/practices.

This was not a longitudinal study and we do not have access to panel data at the patient level that would allow us to conduct a DiD analysis. For instance, we do not have data on patients before they entered the pilot. The evaluation had to be designed around a pilot that had already been established and only lasted 12 months.

17. If most patients are from Westminster PCT, a separate table and paragraph comparing the pilot patients and GPPS patients should be added.

We do not think a separate table or paragraph presenting the characteristics of Westminster pilot patients versus GPPS patients in general would add a great deal since the pilot patient population is so dominated by patients from Westminster accounting for over 70% of OARPs and DPs. However, we have now provided the number of day and out of area registered patients from each of the PCTs.

18. The conclusions of the study are weak and could be improved by using models where the authors could include not only the patient characteristics but also the practice characteristics.

We do not feel it appropriate to carry out any modelling because we have small self-selected samples of patients, we cannot relate patients to the practices they attended, and we have very few patient and practice characteristics. So we focused instead on describing the patient experience, and comparing it with patients from the GPPS for practices participating in the pilot. Also, the sample sizes were too small for this sort of analysis (see comment above).
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19. "The implications for research and practice" show that this work needs to me taken further to answer important questions. However, the access to urgent care is not constrain by the location of patients' practice, since patients can access accident and emergency departments, urgent care centres, walk in centres or GPs out of hours.

This research team has since published a policy analysis of the impact of removing practice boundaries in general practice on the English NHS which makes the point that there are a number of different ways of improving patient access to urgent care including urgent care centres, walk-in centres and GP out-of-hours services. We have inserted a reference to this for further reading and added a few words to make this clear as follows:

“It is possible that a range of drawbacks of the scheme will only emerge over a longer period (see [Mays et al, forthcoming] for a policy analysis on the impact of removing practice boundaries as one among a number of ways of improving access to urgent care in the English NHS). “

Response to reviewer 2:

I thought this was a very clearly-written article on an interesting and highly relevant topic. You are clear about the limitations of the study yet it is a valuable contribution to the literature.

I just had a few observations/questions:
You excluded under 18s yet they are an important high-use group - did you consider surveying/interviewing their guardians?

We chose to only include pilot patients over the age of 18 because we wished to compare pilot and non-pilot patients’ experiences and the GP patient survey is only administered to patients over 18 years. An additional reason for not including under-18s was our awareness that some of the day patients under 18 years of age might well have attended the GP practice without their parents’ or guardians’ knowledge or support, and they might not wished us to contact them in case the fact of

their visit came to light as a result.

In other cases, it was likely that the decision to attend had been taken by a parent or carer and they might be more appropriate to interview, but we would probably have to interview both parent/carer and child, since the former would probably have made the choice and the latter experienced the care. We did not feel that we could take on the extra work involved in the very brief window of the pilot as we were not permitted to approach patients directly under the terms of our research ethics approval.

A brief explanation of this has been added to our methods section:

“Pilot patients under 18 years were excluded because the GP patient survey is only administered to over 18s.”

Minor question re numbers: on page 5 under 'pilot patient characteristics', numbers of patients are 1108 and 250 yet total numbers cited elsewhere are 886 and 188. I probably just overlooked where you explain this difference but maybe it should be made clearer?

This is the difference between the total number of participating pilot patients and the survey samples. This has now been clarified in the Abstract, and Methods, and now reads as follows:

“We conducted a postal survey of all day (64/188, 34% response rate) and out of area registered (315/886, 36%) patients aged 18 years and over and with a permanent address in the UK. Out of 1358 pilot patients, 284 pilot patients were not included in the survey, of these, 260 were aged under 18…”

In the comparisons with existing literature, is there any more you could say about the use of walk in clinics? Do we understand how and which patients use them and how this is different to the patients in your study? I suspect that information isn't known but if there is any further comparison you can draw between patients using WICs and those using your sample practices, it would be very interesting.

We have considered this comment and while we could make some comparisons between patterns of use of the day patient option and walk-in centres, we were hesitant to do so because we do not have any clinical information for out of area patients and the day patient option will not be continued after the pilot . The two practices that reported over half of all day patient visits also operated all day walk-in services, so we were unsure how such substitution was being managed at the practice level.

As we do not have information on reasons for attendance for the more numerous out of area registered patients and we are not confident that we assessed reasons for attending among the day patients in a way comparable with previous studies of WICS, we did not think it was appropriate to draw any explicit comparisons between the pilot day patients and WIC patients.

We were also unable to know how many patients presented at a participating practice with the intent of being a day patient, but instead registered as an out of area patient.

VERSION 2 – REVIEW

REVIEWER	Natasha Curry Nuffiled Trust, UK
REVIEW RETURNED	28-Nov-2014

GENERAL COMMENTS	No comments to add - my comments on a previous draft have been

	addressed.